Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1997

SUSAN A. BJURMAN and GEORGE A. BJURMAN,
Co-Executors of the Will of Dorothy M. Bjurman,

Petitioners,

vs.

TRANSAMERICA CORPORATION EMPLOYEES
HEALTH CARE PLAN,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the court of appeals, applying settled legal principles to its review of a detailed administrative record, properly held that it should defer to an ERISA plan administrator's reasonable conclusion, supported by substantial medical evidence, that 24-hour home nursing care was not covered by the plan.

2. Whether the court of appeals properly held that the insurance doctrines of *contra proferentem* and "reasonable expectations" are inapplicable to review of a plan administrator's interpretation of a self-funded ERISA plan where the plan expressly delegates to the administrator the right to interpret ambiguous plan provisions.

CORPORATE DISCLOSURE PURSUANT TO RULE 29.6

Respondent Transamerica Corporation Employees Health Care Plan (the "Plan") is not a corporation. However, Transamerica Corporation, the Plan Administrator and the company whose employees are beneficiaries of the Plan, is a corporation. It has no parent company and no nonwholly owned direct subsidiaries.

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STATEMENT OF THE CASE

I. NATURE OF THE CASE AND THE PROCEEDINGS BELOW

This case involved a claim by petitioners that an ERISA-governed health care plan (the "Plan") should have paid for seven months of 24-hour-a-day, seven-days-a-week nursing care petitioners had ordered for their mother, Dorothy Bjurman. From the outset, petitioners were advised by the claims administrator for the Plan that the Plan would not cover that part of the around-the-clock expense that was custodial care because the Plan covered only home health care that was "medically necessary." Petitioners ordered the 24-hour care anyway and appealed the partial denial of coverage to the Plan Administrator.

Relying on the opinions of five independent medical professionals, detailed nursing notes and other substantial medical evidence, the Plan Administrator determined that three nursing visits per week were sufficient to meet Mrs. Bjurman's "medically necessary" needs and that the additional care ordered by petitioners was not "medically necessary" (an express requirement for Plan coverage) and was "custodial" in nature (an express exclusion from Plan coverage).

Petitioners then filed an action in California state court in July 1993 seeking to recover 100% of the amount they had paid for 24-hour care. After respondent removed the action to the United States District Court for the Central District of California, the parties filed cross-motions for summary judgment. The district court granted petitioners' motion and denied respondent's

motion. Although it concluded that the Plan Administrator's interpretation of "custodial" was reasonable, App. 19, the district court held that because it felt that term was ambiguous, the doctrines of *contra proferentem* and "reasonable expectations" required the Plan Administrator to accept the contrary interpretation proffered by petitioners.

Respondent Plan appealed to the United States Court of Appeals for the Ninth Circuit. In an unpublished memorandum decision filed March 13, 1997, a Ninth Circuit panel unanimously reversed the district court and remanded with instructions to enter summary judgment for the Plan. App. 1-2. The panel succinctly held that, because the Plan is self-funded and expressly delegates to the Plan Administrator the right to interpret ambiguous provisions, the district court had improperly applied the doctrines of *contra proferentem* and reasonable expectations to the Plan's custodial care exclusion and should have deferred to the Plan Administrator's reasonable interpretation of the provision. App. 1-2.

The panel also concluded that the district court should have deferred to the administrator's reasonable conclusion, supported by medical evidence in the record, that 24-hour nursing care for Mrs. Bjurman was not medically necessary. App. 2.

The panel on April 25, 1997 denied a petition for rehearing and advised petitioners that no active judge of the full court had requested a vote on petitioners' suggestion for a rehearing en banc. App. 3.

II. STATEMENT OF FACTS

Dorothy Bjurman was a beneficiary of the Transamerica Corporation Employees Health Care Plan (the "Plan") through her late husband, a former Transamerica executive.

The Plan designates the Transamerica Corporation Benefits Administration Committee (the "Committee") to carry out Transamerica's role as Plan Administrator. The Plan delegates discretionary authority to the Committee to, among other things, "interpret the provisions of the Plan and to determine any question arising under, or in connection with the administration or operation of, the Plan." ER 54-55. The Plan further provides that "all decisions of the Committee, and any action taken by it in respect of the Plan and within the powers granted to it under the Plan, shall be conclusive and binding on all persons." ER 56.

The Plan covers "home health care" expense in certain circumstances, providing in conspicuously-placed language that:

- "Home health care does not include housekeeping or custodial care." ER 106-07
- "Covered Expense does not include . . . Expense for custodial care, except when provided by a Hospice." ER 109
- "Please note: Home health care must be medically necessary and prescribed by a doctor. It does not include custodial care such as feeding, bathing, or administering medication." ER 282.

In April 1992, Mrs. Bjurman was released from the hospital following surgery. Her daughter, petitioner Susan Bjurman, promptly retained a private-duty nursing agency to provide 24-hour nursing services to Mrs. Bjurman at home while Susan Bjurman worked. ER 370-71. A series of treatment plans from Mrs. Bjurman's doctor outlined a variety of assessment and monitoring functions for the nurses to perform. ER 424-25, 450-51, 609-10. With the exception of several intermittent hospitalizations, the 24-hour-a-day private nursing services continued until Mrs. Bjurman's final hospitalization in December 1992.

The nursing agency first requested authorization for 24-hour home nursing care from the Plan's claims administrator, Prudential Health Care, in late June 1992. ER 426. Prudential promptly responded that coverage for continuing nursing care would probably be denied because the activities specified by Mrs. Bjurman's doctor appeared to be custodial, and the Plan excluded custodial care. ER 432. After obtaining additional information from Mrs. Bjurman's doctor and the hospital, and reviewing the detailed nursing notes that documented the care actually being provided by the private duty nurses, Prudential's medical staff (including five different professionals) concluded that most of the 24-hour care was custodial in nature and not medically necessary, but that intermittent R.N. visits would be authorized to attend to any "medically necessary" needs. ER 496-97, 526, 536, 538, 560-69, 598-99, 601-02, 651-52.

Petitioners appealed Prudential's August 1992 denial to the Plan Committee. ER 606. The Committee's secretary requested that Prudential's Regional Appeals Committee examine the claim and report to the Committee. ER 657. After reviewing hundreds of pages of nursing notes, the Prudential doctors again concluded that most of the services rendered to Mrs. Bjurman were custodial and not medically necessary. ER 670.

Prudential sent a detailed letter to the Plan Committee recapping the entire chronology of the claim. ER 666-71. The manager of Prudential's Claim Technical Services Division then met with the full Plan Committee to further review the claim. ER 679-80. The Committee's minutes reflect that, "after extensive discussion, the Committee agreed that the care provided to Mrs. Dorothy Bjurman was primarily custodial care and therefore expressly excluded under the [Plan]. The Committee agreed with Prudential's recommendation to provide benefits for three visits per week by an R.N. during the period when Mrs. Bjurman was not hospitalized." ER 680. After the denial of a further appeal to the Committee, this lawsuit followed.

REASONS FOR DENYING THE WRIT

I. PETITIONERS FAILED TO RAISE IN THE COURT OF APPEALS ANY OF THE THREE QUESTIONS RELATING TO A 1989 SPD THAT THEY SEEK TO PRESENT BY THEIR PETITION TO THIS COURT

Petitioners, after citing the portions of ERISA that govern the content of a summary plan description

("SPD"), seek to present three questions for this Court's review regarding interpretation of what they call "an ambiguous exclusionary term contained in a SPD." Pet. at i. Throughout their petition, petitioners argue that the SPD they have in mind is a January 1989 supplement they call the "1989 SPD." Pet. at 3-4, 5-6, 13, 17-18.

No aspect of these questions was presented to the court of appeals. In their brief, petitioners nowhere cited any ERISA provision relating to SPDs. Nowhere did they argue to the court of appeals that the Plan Administrator here in any way violated the SPD provisions of ERISA.[1] Most significantly, nowhere did they even bring to the attention of the court of appeals the 1989 SPD they now ask this Court to review. Instead, petitioners' argument to the court of appeals focused entirely on interpretation of language found in the ***Plan*** and not in ***any*** SPD, much less the 1989 version on which they now seek to rely. *See* Br. of Appellees filed March 18, 1996 at 29.[2]

Petitioners' failure to raise these issues in the court of appeals precludes their belated effort to present them for review by this Court. *See Delta Air Lines, Inc.* v. *August*, 450 U.S. 346, 362 (1981) (question presented in petition but not raised in court of appeals "is not properly before us").

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[1] The district court had expressly declined to reach this issue. App. 16-17 at n.7.

[2] Petitioners' argument to the court of appeals was also silent as to all other aspects of the "Medicare" argument they now seek to present for this Court's review in their third question. Pet. at i, 17-18.

II. THE PLAN ADMINISTRATOR'S DETERMINATION OF PETITIONERS' CLAIM TURNED ON UNIQUE FACTS, NOT ON ANY IMPORTANT OR RECURRING LEGAL ISSUE THAT MERITS THIS COURT'S REVIEW

Petitioners' expression of their case has undergone a remarkable metamorphosis since they argued it to the court of appeals. As they told the court below, "Plaintiffs have stressed throughout this litigation that this is a ***fact-intensive*** case." Br. of Appellees at 5 (emphasis added). They went out of their way to "reiterate that the ***unique facts*** of this case are of ***critical import***. . . . " *Id.* (emphasis added). They did not finish reciting those "unique facts" until page 23 of their 35-page brief.

Now, however, with the case having been decided adversely to them, petitioners hope to walk away from the "unique facts" that compelled that result. Instead, they attempt to manufacture a supposed conflict among the circuits by relying on cases they never mentioned in the court of appeals and proclaiming that there is an "eminent need for uniformity of law." Pet. at 12.

In points III and IV below, we debunk the suggestion that petitioners' newly-cited cases in fact reveal any conflict among the circuits. But even if there were a conflict regarding application of the insurance doctrines of *contra proferentem* and "reasonable expectations" to the interpretation of ambiguous language in a self-funded ERISA plan that gives its administrator discretion over plan interpretation, it would be a tempest in a teapot. Resolution of petitioners' claims by the Plan Administrator turned entirely on the "unique facts" petitioners argued

at length to the court of appeals, and not on any interpretation of Plan language.

There was no dispute before the Plan Administrator as to what the term "custodial" ***meant***. The dispute centered on the nature of the nursing services Mrs. Bjurman received and whether anything beyond intermittent nursing visits was required to satisfy her "medically necessary," non-custodial needs.

The Plan Committee relied on the opinions of five different medical professionals on Prudential's staff in concluding that three nursing visits per week were sufficient to meet Mrs. Bjurman's medical needs and that the balance of the care prescribed for her was custodial.[3]

Under this Court's decision in *Firestone Tire and Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), and its progeny, the Plan Administrator's review of the medical evidence was within its discretion and may not be disturbed where it is supported by substantial medical evidence. Here, the court of appeals was entirely correct in holding that

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[3] Appellate decisions throughout the country have routinely upheld plan administrator decisions as to whether nursing services are "medically necessary" or "custodial" in circumstances like those here. *See, e.g., O'Connor* v. *Central Virginia U.F.C.W.*, 945 F.2d 799 (4th Cir. 1991); *Cathey* v. *Dow Chemical Co. Med. Care Program*, 907 F.2d 554 (5th Cir. 1990), *cert. denied*, 498 U.S. 1087 (1991); *Chambers* v. *Family Health Plan Corp.*, 100 F.3d 818 (10th Cir. 1996); *Birdsell* v. *United Parcel Service*, 94 F.3d 1130 (8th Cir. 1996); *Wald* v. *Southwestern Bell etc. Plan*, 83 F.2d 1002 (8th Cir. 1996); *Maune* v. *IBEW, Local No. 1 etc. Fund*, 83 F.3d 959 (8th Cir. 1996); *Buttram* v. *Central States etc. Fund*, 76 F.3d 896 (8th Cir. 1996).

"while there was a conflict in the medical evidence presented by the parties, the plan's doctors considered and rejected the medical necessity of around-the-clock care to protect Bjurman against the risk of aspiration and other complications. *E.g.*, ER at 659. We must defer to this reasonable conclusion. *See Barnett* v. *Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 417 (9th Cir. 1994). And we do." App. 2.

That conclusion of law, compelled by the record and the *Firestone* standard of review, renders entirely irrelevant the questions petitioners seek to present for this Court's review.

III. THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE QUESTION WHETHER A PLAN ADMINISTRATOR'S EXPRESS DISCRETION TO INTERPRET AMBIGUOUS TERMS IN A SELF-FUNDED PLAN CAN BE OVERRIDDEN BY A BENEFICIARY'S CLAIM OF "REASONABLE EXPECTATIONS."

Petitioners attempt to argue that the fundamental rule embodied in *Firestone* v. *Bruch* and its progeny – that the interpretation or application of plan language by a plan administrator having full discretionary authority to do so is entitled to deference and should be upheld unless arbitrary and capricious – should be ignored where a plan beneficiary claims a "reasonable expectation" of a different result. They rely on cases holding that ambiguous terms in insurance policies should be interpreted in a manner consistent with the reasonable expectations of the insured.

As the court of appeals held in this case, because the self-funded plan at issue "expressly delegates to plan administrators the right to interpret ambiguous provisions," App. 1, "the district court should have deferred to the plan committee's reasonable interpretation" of its coverage provisions. *Winters* v. *Costco Wholesale Corp.*, 49 F.3d 550, 553 (9th Cir.), *cert. denied*, 116 S.Ct. 276 (1995). App. 2.

Petitioners argue that both *Winters* and cases from other circuits apply the doctrine of "reasonable expectations" to self-funded plans that confer discretionary authority on plan administrators. Pet. at 10-12. They are wrong.

In *Winters*, the Ninth Circuit made clear that its earlier decision in *Saltarelli* v. *Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994), applied the "reasonable expectations" doctrine only in the insurance context, noting that the *Saltarelli* court held that "the doctrine of reasonable expectations applies as a principal of federal common law controlling interpretation of ERISA-governed ***insurance contracts***." 49 F.3d at 554 (emphasis added). *See also, Peterson* v. *American Life & Health Ins. Co.*, 48 F.3d 404, 411 (9th Cir. 1995) (*Saltarelli* applies "only when a provision in an insurance policy is either ambiguous or not sufficiently conspicuous"); *Babikian* v. *Paul Revere Life Ins. Co.*, 63 F.3d 837, 842 (9th Cir. 1995) (*Saltarelli* involved insurance policy interpretation and does not apply where an insurance policy exclusion is conspicuous).

Moreover, as the Ninth Circuit recently said in *Snow* v. *Standard Ins. Co.*, 87 F.3d 327, 330 n.1 (9th Cir. 1996), the doctrine of reasonable expectations cannot be used to

strip a plan administrator of discretion even in an ERISA-governed ***insurance*** plan.

Nor do the cases petitioners cite from other circuits take a contrary view. In *Mitchell* v. *Eastman Kodak Co.*, 113 F.3d 433, 443 (3d Cir. 1997), the issue was not plan ambiguity, but imposition by the plan administrator of a requirement (clinical evidence of etiology for chronic fatigue syndrome) nowhere found in the plan. No resort to the insurance doctrine of "reasonable expectations" is necessary to conclude that a plan administrator's discretion does not extend to making up new requirements that are absent from the plan's language.

In *Bailey* v. *Blue Cross & Blue Shield*, 67 F.3d 53, 57 (4th Cir. 1995), the doctrine of "reasonable expectations" was applied to an insurance policy, not a self-funded plan, and the court applied a less deferential standard of review because the insurer had an obvious conflict of interest. Similarly, *Wheeler* v. *Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995), involved an insured plan,[4] and the court expressly applied a *de novo* standard of review because the plan gave the plan administrator no discretion. *Id.* at 638.

Finally, in *Lutheran Med. Ctr.* v. *Contractors Health Plan*, 25 F.3d 616, 621 (8th Cir. 1994), the court held that a summary plan description saying that mental disorders are covered created an expectation of coverage for

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[4] Petitioners erroneously claim that the plan in *Wheeler* was self-funded. Pet. at 11. Although initially self-funded, the plan in *Wheeler* was reinsured, 62 F.3d at 637, and the court repeatedly referred to the plan as "insurance" and the beneficiaries as "insureds." *Id.* at 638-40.

depression, such that the plan administrator could not refuse to pay for treatment for depression merely because it deemed plaintiff a suicide risk and the plan excluded coverage for suicide attempts. Thus the case turned on clear language in an SPD, not ambiguous language in a plan.[5]

In sum, none of the cases on which petitioners rely contain support for their plea that this Court abandon *Firestone* and hereafter allow a plan administrator's express discretion to interpret ambiguous plan language to be undermined by a beneficiary's claimed expectation of a different interpretation.

IV. THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE QUESTION WHETHER A PLAN ADMINISTRATOR'S EXPRESS DISCRETION TO INTERPRET AMBIGUOUS TERMS IN A SELF-FUNDED PLAN CAN BE OVERRIDDEN BY THE INSURANCE DOCTRINE OF *CONTRA PROFERENTEM*

Petitioners also seek to argue that the insurance doctrine of *contra proferentem* – construing ambiguous provisions of insurance policies against the insurer – should be applied to self-funded plans as well, even where the plan

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[5] Moreover, the Eighth Circuit has recently and repeatedly upheld plan administrators' decisions that, like that here, are based on their own medical opinions regarding medical necessity or custodial care, notwithstanding the contrary opinion of a beneficiary's physicians. *See, e.g, Birdsell* v. *UPS, supra,* 94 F.3d at 1131-32; *Wald* v. *Southwestern Bell, supra,* 83 F.3d at 1008; *Maune* v. *IBEW, supra,* 83 F.3d at 963; *Buttram* v. *Central States, supra,* 76 F.3d at 902 *n.*9.

gives full discretion to the plan administrator to interpret ambiguous terms. Pet. at 14-16. Again, petitioners miss the mark.

They begin by citing the Ninth Circuit's opinion in *Kunin* v. *Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990) as the "seminal decision" regarding application of *contra proferentem* in ERISA cases. Pet. at 14. *Kunin*, however, involved an insurance policy, and the Ninth Circuit's subsequent decisions have repeatedly made clear that the doctrine does not apply to either self-funded plans[6] ***or*** to plans that give discretion over plan interpretation to the plan administrator.[7] Where a plan is ***both*** self-funded ***and*** confers discretion on the plan administrator, as in this case, it is doubly impermissible to rely on *contra proferentem* to limit or eliminate the plan administrator's discretion.

Although petitioners attempt to suggest that other circuits disagree with the Ninth Circuit, the cases they cite demonstrate the contrary. In *Collins* v. *American Cast Iron Pipe Co.*, 105 F.3d 1368, 1371 (11th Cir. 1997), the court ***reversed*** a judgment for plaintiff that had been based on alleged ambiguity as between a plan and an

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[6] *Eley* v. *Boeing Co.*, 945 F.2d 276, 280 (9th Cir. 1991); *Winters* v. *Costco*, *supra*, 49 F.3d 550, 554 (9th Cir. 1995).

[7] *Snow* v. *Standard Ins. Co.*, *supra*, 87 F.3d at 330 *n.*1 (*contra proferentem* cannot be used to strip a plan administrator of discretion even in an insured plan); *Winters*, *supra*, 49 F.3d at 554; *Atwood* v. *Newmont Gold Co.*, 45 F.3d 1317, 1324 (9th Cir. 1995)(application of *contra proferentem* would "completely do away with the abuse of discretion standard we must apply").

SPD.[8] It cited its earlier decision in *Lee* v. *Blue Cross, etc.*, 10 F.3d 1547 (11th Cir. 1994), as the basis of plaintiff's *contra proferentem* argument, but *Lee* was expressly limited to insurance contracts. *Id.* at 1557. In *Nightingale* v. *Blue Cross*, 41 F.3d 1476, 1481 (11th Cir.), *cert. denied*, 115 S.Ct. 2002 (1995), the court applied a *de novo* standard of review and cited its earlier decision in the insurance context of *Lee* as the basis for application of *contra proferentem*.

In *Doe* v. *Group Hosp. & Med. Services*, 3 F.3d 80, 89 (4th Cir. 1993), the court likewise dealt only with an insured plan and relied only on cases dealing with insurance policies. In *Heasley* v. *Belden & Blake Corp.*, 2 F.3d 1249, 1258 (3d Cir. 1993), the court examined *contra proferentem* only in determining whether the plan conferred discretion on the plan administrator sufficiently clearly to warrant a deferential standard of review, and noted that it had declined to apply *contra proferentem* in non-insurance ERISA cases. *Id.* at 1257.

Finally, the court in *Germany* v. *Op. Eng. Trust Fund*, 789 F. Supp. 1165 (D.D.C. 1992), confirmed that under a deferential standard of review "it is for the trustees, and

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[8] Similarly in *Wahlin* v. *Sears, Roebuck & Co.*, 78 F.3d 1232 (7th Cir. 1996), the court of appeals ***reversed*** a district court judgment for plaintiff, finding that there were no ambiguous plan terms that would allow the court to "construe them in favor of the insured" as in the insurance cases it cited. *Id.* at 1235. Relying on *Winters, supra*, the Seventh Circuit has subsequently held that *contra proferentem* is inapplicable where, as here, a plan administrator has discretionary authority to construe plan terms. *Morton v. Smith*, 91 F.3d 867, 871 n.1 (7th Cir. 1996).

not the courts, to choose between two reasonable alternatives" in interpreting plan language. *Id.* at 1167. The court declined to defer to the plan administrator only in interpreting the ERISA statute itself. *Id.*

In sum, petitioners' cases entirely belie their claim of a "confounded state of the law." Pet. at 17. No court has applied *contra proferentem* to strip a plan administrator of discretion to interpret ambiguous plan terms where, as here, such discretion is conferred by the terms of a self-funded plan.

CONCLUSION

For the reasons given above, respondent respectfully requests that the petition be denied.

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Dated: August 25, 1997.